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THE OCULAR EVIDENCES OF HYSTERIA.

WITH ILLUSTRATIVE CASES.

By Casey A. Wood, M.D.,
PROFESSOR OF OPHTHALMOLOGY IN THE POST-GRADUATE MEDICAL SCHOOL, CHICAGO;
FELLOW OF THE AMERICAN ACADEMY OF MEDICINE.

NOTWITHSTANDING the importance attached by writers to the eye-symptoms in the diagnosis of hysteria, and although Charcot himself years ago pointed out their extreme value in establishing the identity of this neurosis, they have not received the attention they deserve. Of all the sense-organs, not excepting the skin, the visual apparatus furnishes the most constant, the most easily detected, and the most conclusive signs of the hysterical presence. This is my apology for importing into this essay a description of the simpler methods employed in making an examination of the eye for evidences of the disease. Although well known to every ophthalmologist, they are often unfamiliar to the general student, and will consequently bear description.

My purpose is to dwell only upon the ocular signs of hysteria that are most commonly found in cases of *petite* and *grande hystérie,* as well as to furnish a description of the means by which they may be accurately determined, even by those who make no pretence to a knowledge of ophthalmology, who are not expert in the use of the ophthalmoscope, and who are not familiar with even the rudiments of physiological optics.

In the cases presented the diagnosis of hysteria was made from the eye-symptoms and ocular signs; in most instances confirmatory evidence was subsequently obtained by a more general examination of the patient.

Probably the most important hysterical eye-signs are anomalies of accommodation—affections of the ciliary muscle.[1] Parinaud insists that even in the absence of other hysterical stigmata, the neurosis can be confidently diagnosticated when ciliary spasm (of the kind to be described) is present. In hysterical spasm the eye acts as if it were under the influence of pilocarpine or eserine. The accommodative range is limited at both ends, and the patient reads or does other near work with difficulty; for these reasons, the condition has been called hysterical insufficiency of accommodation, ciliary hyperæsthesia, ciliary paresis or paralysis, and painful accommodation. Every degree of spasm may be present, just as one sees all degrees of hysterical muscle-contracture elsewhere in the body. The *punctum proximum* and *punctum remotum* may approach or even coincide, and the patient reads fine print nearer the eye than usual or at a fixed point. This, when it occurs, may be regarded as conclusive evidence of hysteria. As a rule, however, there is a marked, but incomplete, spasm of accommodation—the near point for distinct vision being always nearer the eye than normal.

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[1] The reader is reminded that the nearest point at which the eye can distinctly see the outlines of small objects held directly in front of it is called the punctum proximum (or P), the greatest distance being the punctum remotum (R). The distance between these is the range of accommodation, not to be confounded with the force exercised by the ciliary muscle in looking from P to R—the amplitude of accommodation. Without going further into this

Hysterical spasm of the ciliary muscle usually produces false myopia and hysterical near-sightedness for distance, which, just like the axial variety, is improved by concave glasses. If there be a doubt as to the character of this short-sightedness, a single drop of a solution of atropia (1 per cent. in patients under thirty-five years of age, ½ per cent. for those between thirty-five and forty-five) instilled into each eye, after meals, for two days, will disclose the true refraction.

CASE I. *Hysterical contracture of accommodation, with recurrent amblyopia and defective visual fields.*—B. E., aged ten years, well nourished, but a nervous, an ambitious and much-worked school girl, came to me on account of very defective vision. Three years previously she had had scarlet fever and, two years before, diphtheria. The latter was a mild attack, but the scarlet fever kept her in the house for over a month, and she was very ill. She had no renal or cardiac complication. In addition to the defective vision she complained of confusion of print for six months before I saw her. For that period, also, she experienced difficulty in distinguishing characters on the blackboard. She has constant frontal headaches and photophobia. She holds her book close to her face in reading, and contracts her brows in her efforts to see. V., R. and L. = $\frac{1}{5}$ —; Jaeger II. is read with difficulty at 12 cm. in each eye. At 15 cm. she can distinguish words of Jaeger IV. Under atropine for a week her vision improved to 20/xl —, and in two weeks she was able to read Jaeger II. fluently at 15 cm. and her symptoms greatly improved. Treatment: abstinence from all near work, outdoor life, strychnine, galvanism, and atropinization. Under this treatment her eyes, as well as her general health, grew gradually better, although she had many relapses. Six months later her vision

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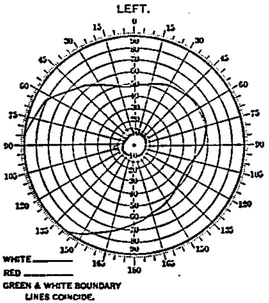
matter, a fair test of the accommodative range may be made (by the aid of correcting glasses if these are needed) by observing (1) how near the eye and (2) how far away the patient can read the finest (diamond) print. In fairly normal eyes (or eyes fitted with appropriate distant-glasses) the near point (P) tested in this way should be 7 cm. at ten years of age, 8 cm. at fifteen, 10 cm. at twenty, 11.7 cm. at twenty-five, 14 cm. at thirty, 18 cm. at thirty-five, 22 cm. at forty, 28.6 cm. at forty-five, and 40.5 cm. at fifty.

was 6/vi in either eye, and she could read Jaeger II. at 30 cm. and had a range of 20 cm. One month previously her vision in either eye was 6/vi, Jaeger II. at 18 cm., and a range of 5 cm. It is now nearly three years since I first began to treat her, and she has had a couple of relapses, always attended by lowering of central vision and marked ciliary contracture. Her fundi, examined frequently, have always been normal. Concave lenses assist the central visual acuity somewhat, but convex glasses have not enabled her to read any better. This patient has shown evidences of hysteria other than the ocular signs. She has had facial hemispasm and anæsthetic areas. The perimeter has shown a great variation in the size of her visual fields. The area for white always approached the normal size as the asthenopic symptoms disappeared, and, although at one time it was contracted to within 15° of the fixation point, it is now practically normal. The color-field did not vary as much as that for white, but there was always a certain correspondence between them. She was never entirely color-blind.

During one relapse, brought on by an injudicious effort to study, her field in the left eye contracted, as shown in Fig. 1. She then had a range of accommodation of 5 cm. (17–12 cm.), and the asthenopia was very marked. The pupillary reactions (light, accommodation, electrical and palpebral) were all very sluggish. There was a doubtful anæsthesia of the left cornea at this time. It is noticeable that the field for red is larger than that for white. In this case the reversal or unusual order of the white and color-fields was very marked, as shown in numerous perimeter charts.

FIG. 1.



Hysterical contraction of the visual field.

Hysterical amblyopia may be so marked that the patient has to be led about the room, or, more usually, it may pass unnoticed by the patient. It is not improper to regard the visual defect as due to an anæsthesia of the perceptive elements of the retina in correspondence with that loss or perversion of sensation exhibited by the skin and mucous membrane in other phases of hysteria. This visual defect is almost always present, and when the central acuity of sight, first determined by test-types, is nearly or quite equal, it will be found on careful inquiry that peripheral vision is uniformly affected. The normal limits of the field of vision are measured by a good, stationary perimeter, obtainable from any optician.[1]

CASE II. *Hysterical amblyopia and amaurosis and paralysis of accommodation in a boy; recovery; hysterical contraction of the fields of vision.*—J. Y., aged nine years, has a healthy parentage. He has been a "mouth-breather," owing to post-nasal adenoid vegetations and enlarged tonsils, ever since the mother can remember. He was sent to a kindergarten when six years of age, when it was noticed that his vision and color-sense were good. At seven he had scarlet fever.

He has been going to the public school for a year and a half, and during the past six months his teacher noticed that he did not see the figures on the blackboard very well and that he held his book close to his face while reading. Quite recently his vision has been very much worse—so much so that he runs against articles of furniture, and has been obliged to leave school. The patient is a bright, well-nourished, intelligent, and precocious boy, who tells a pretty consistent story of his troubles. He has suffered much from nocturnal enuresis during the past year and shows his nervous temperament by never remaining quiet for a minute at a time. Even when his vision became very defective he was constantly moving, wandering about continually from one part of the house to another.

November 17, 1895, the condition of his eyes was as follows: both pupils widely dilated, neither of them contracting more than ¼ their diameter on looking at a near point. They also responded very sluggishly, even to bright light. He perceived hand movements only in each eye, but at 10 cm., after some coaxing, could distinguish words of Jaeger XIV. This attempt, he claimed, brought on frontal headache, which he now has every day. He had marked photophobia. There were absolutely no fundus changes, and the retinal field was uncontracted to a very faint light. He was immediately treated with galvanism, interrupted current, half *ma.*, for five minutes at a time three times a week, and given a tonic containing strychnine. Atropine was prescribed, and, by the aid of skiascopy and the ophthalmoscope, his total refraction was found to be + 1 D. in each eye. After three weeks his adenoids and tonsils were removed.

January 17, 1896. Patient is decidedly better in all respects. V., L. = words of Jaeger I. and 20/xx, but the fine print can be read best at 20 cm., becoming more indistinct when the test-words are brought nearer or removed further from the eye. He was allowed to go to school for a few hours daily.

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[1] The examination of hysteropes requires particular care, lest the patient's eye become fatigued and the defect be exaggerated or improperly measured. The perceptive elements of the retina in an hysterical subject are not very sensitive to form and white objects, and his ciliary muscle is usually weak. There should be frequent interruptions, therefore, of the work of perimetric measurement, and only one eye examined at a sitting. It should be remembered, also, that the hysterope is often greatly influenced by suggestion, and it is always wise to make "control" experiments when a subjective test is being used.

28th. Had to leave school owing to return of confusion of print, photophobia, and frontal pains. V., L. = $\frac{4}{8}$ and words of Jaeger X.; V., R = $\frac{4}{5}$ and words of Jaeger VI. The Jaeger types are read best at 12 and 15 cm., respectively; there is practically no accommodative range.

The patient was now put under atropine for two weeks, but, although there were fewer headaches, he experienced no other improvement. On recovery from the cycloplegia, V. = $\frac{1}{10}$ and words of Jaeger XVI. in either eye. No improvement with glasses for distance or near.

March 17th. Patient almost as bad as ever; V. = $\frac{1}{15}$ *u. o.* and no Jaeger. He was given galvanism regularly, and in the following June his visual acuity was $\frac{2}{3}$ in each eye, and he was able to read Jaeger II., with difficulty, at from 15 to 18 cm.

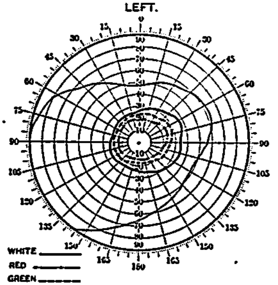
With slight relapses, this improvement held until the following October, when he was brought to me with V., R. = $\frac{8}{100}$ and words of Jaeger XII. at 15 cm.; V., L. = $\frac{1}{10}$ and Jaeger XII. at 16 to 18 cm. He now complained of photophobia, pain in eyes and forehead, and showed, for the first time, evidences of blepharospasm. He had a return of nearly all the signs of ciliary contracture that were present when I first saw him. I again thoroughly atropinized both eyes, and in six days had the satisfaction of discovering that he could read Jaeger I. at 25 cm. with + 4 D., and with + 1 D. got nearly normal vision in the distance. The atropine was continued for ten days and the boy sent to a manual training school, where it was arranged that he should use his eyes as little as possible for near-work. He has since had very few relapses. When twitching of the lids, photophobia, dimness of vision, or any of his old symptoms recur, he is kept from school and atropine employed. This appears not only to relieve the ciliary spasm, but has an excellent moral effect upon the patient, who is very fond of his work. When last seen he had some difficulty in seeing the blackboard, and I found his vision to be as follows: V., R. = $\frac{1}{2}$ and Jaeger I. at 12 to 15 cm.; V., L. = $\frac{2}{3}$ and Jaeger I. at 10 to 13 cm.

I never was able to demonstrate diplopia or polyopia in this case, although the patient presented many other local and general stigmata of hysteria.

The fields of vision in this case were very interesting. As soon as the patient could see a test-object 10 mm. square he was examined carefully with the perimeter many times. His field for white has never widened beyond 40°, even when his central acuity was normal. The narrowing of the field has always been regular. (See Figs. 2 and 3.) There have not been any sector-like defects or scotomata, relative or positive. In the early stages of the examination, and upon two other occasions, the boundary of the field for white coincided with the tenth parallel, and the color areas were almost abolished, but the average measurements have been about as follows: white, 30° all round; red, from 20° to 25°; green, from 25° to 30°. These measurements have varied greatly, owing to the ease with which the eyes were fatigued. Indeed, the fields for green and red have, on several occasions, measured about the same as that for white. There has never been the slightest fundus alteration.

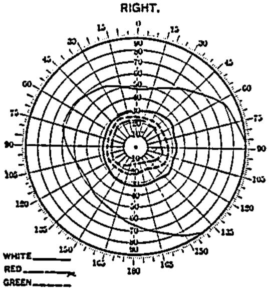
Contraction of the Fields of Vision. The predominant peculiarity of an hysterical contraction of the visual field is that while, in every other disease where peripheral limitations occur, the color-field is affected *pari passu*, or in greater proportion than the field of white, in hysterical amblyopia the field is less affected for colors than is the field for white, just the reverse of that which obtains in other nervous affections. Even where the field for white is still the largest it can usually be shown (where there is no perimetric defect) that the visual field for

FIG. 2.



Field of vision in Case II., hysterical amblyopia. V — 2/3.

FIG. 3.



Field of vision in Case II. V — ½.

red is larger than that for blue, and these measurements should always be taken in doubtful cases. Excellent examples of this strange phenomenon are exhibited by most of the cases here reported. This reversal of the order and extent of the fields for white and colors is, when present, positive evidence of the existence of hysteria; it cannot be simulated, and is caused by no other ocular disorder. It is readily determined, and possesses a diagnostic value equal to the anæsthesia of the glottis and pharynx so frequently referred to as pathognomonic of this neurosis.

Blepharospasm. Although contracture and spasm of almost every member of the oculo-muscular system has been observed in hysteria, many of these are differentiated from true paresis and insufficiencies with some difficulty. A few are, however, so evidently functional disorders, and their detection is so comparatively easy, that I do not hesitate to refer to them as hysterical stigmata with which every one should be acquainted.

Even before the days of modern ophthalmology it was noticed that spasm of the orbicular muscles was frequently associated with amaurosis and amblyopia, even when there was no apparent structural disease of the ocular apparatus. Such a state of affairs should make us suspect and further examine the patient for hysteria. All such forms of spasm of the orbicularis—tonic, clonic, transitory or permanent, unilateral or bilateral—are probably hysteric. If central or peripheral excitants competent to produce the spasm can be excluded, and if other hysterical stigmata be present, the probability becomes a certainty. The orbicular contraction may be a part of a facial or more extended hemispasm, or it may be limited to a single muscle.

CASE III. *Intermittent and chronic spasm of the right orbicularis and other facial muscles in an hysterical subject.*—Mrs. J. E. is the daughter of a distinctly neurotic mother, but did not herself exhibit signs of hysteria until a year ago, after a double ovariotomy. Following recovery from the operation she became easily excited, nervous, and had fits of crying. She also complained of transitory numbness of her arm and corresponding leg, accompanied by a feeling of general exhaustion. Complains much of headache affecting the vertex and occipital regions. Her range of accommodation is reduced one-third, and she complains of photophobia and asthenopia. Two weeks ago the lids of the right eye began to twitch, and this symptom has increased in severity since then. Some days it entirely disappears, to return on the slightest excitement or on attempting to read or sew. Her central vision is unaffected.

I kept this patient under observation for several months, and was unable to relieve the spasm, which finally extended to the whole group of facial muscles on the right side, including the masseter and sternomastoid. On several occasions there was some slight twitching of the facial muscles on the left side, but this did not persist. When I last saw her the purely ocular distress had considerably diminished, but the muscular spasm was as marked as ever, in spite of general and local treatment.

Blepharospasm and photophobia are frequently associated in hysterical subjects, and both signs may be very marked. The following case is an example:

CASE IV.—At the instance of Dr. John A. McDonnell, I examined Mrs. B., aged thirty-one years, who had been in ill health and a pronounced neurasthenic for many years. Three months before my visit she began to complain of inability to use her eyes for more than a few minutes at a time. Later, she complained of photophobia and twitching of the lids. These symptoms increased in intensity until even the least exposure to light brought on "spasm of the lids."

When I saw her she was confined to bed in a room from which every ray of light had been excluded. Window curtains were drawn, shutters closed, and blankets had been pinned over the casements. Her eyes were completely covered with bandages, and over these she held her hands. After some persuasion she allowed a candle to be brought into the room, and by its aid I was able to make out, after removing the bandage, a well-marked bilateral tonic blepharospasm, unaccompanied by redness or tenderness of the globe. Further examination of the eye was impossible, but the patient presented other stigmata of hysteria.

Although the persistent blinking of the eyes that constitutes the usual form of clonic blepharospasm is not necessarily hysterical, it often forms one detail of the neurotic picture. Apart from organic disease of the lids or other parts of the eye, it may properly be regarded as a symptom of hysteria, and will usually prove to be such.

Monocular Diplopia or *Polyopia.* This is a curious hysterical phenomenon—probably the result of ciliary spasm—that may be developed in many hysteropes. I say developed, because the patient is usually unconscious of the double vision as such. It commonly presents itself to him as part of his visual defect. Tests should be made in both a lighted and a darkened room. One eye being covered, a white match is held vertically three or four inches in front of the uncovered eye. The patient is then asked to observe whether the object appears double, as it is slowly moved from its first position to a point three feet away. In most cases the match will present a double image when held quite near the face; the images approach one another and become quite or almost fused as they are removed, to separate again more and more until the metre distance is reached. The match is again from this point gradually brought close to the eye, when the same phenomena, but in reverse order, will be manifested. The second eye is similarly examined, and finally the room is darkened and a further (control) test is made with a candle flame. Sometimes three or more images (polyopia) are observed, and it is usually possible to exclude one or more of these by carefully interposing a card so as to cover various segments of the pupillary area during the examination.

CASE V. *Hysterical, monocular, homonymous diplopia in a neurasthenic woman.*—Mrs. P., aged forty years, has had weak eyes as long as she can remember, and for ten years past has observed double vision when fixing either distant or near objects. This diplopia is lately quite marked when she attempts to read. Her general health is far from good, and she complains of "nervousness." There is no history of injury to the head, of constitutional disease, or of any organic brain lesion. She has never been very strong, and gives a history of several attacks of "nervous prostration." Steady use of the eyes brings on frontal headache and pains in the globes themselves. No glasses have relieved these symptoms, nor have they sensibly diminished the blurring and confusion of print observed whenever she attempts to read. In looking at a distant object the indistinct or second image appears to the right of the clearer one when looking with the right eye and to the left when fixing with the left eye. When her general health is at its best she can sometimes obtain a single, but blurred, image of a near object for a short time by making special efforts to fix.

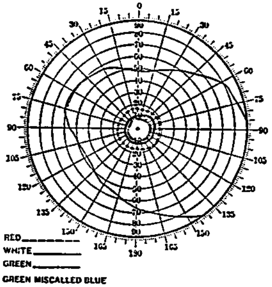
The ordinary tests readily develop the monocular diplopia. In reading the distant test-types each letter is double, the diplopia being more marked with the right eye than with the left. V. $= \frac{2}{3}$ — in either eye. She has a regular hyperopic astigmatism of 1.0 D., and with this corrected the visual acuity is almost 1. On slowly approaching the nasal side of the right (the left excluded) pupil with a card, the second left image is gradually cut off and the patient sees singly. Reversing the experiment, the right image disappears. In the same way both the distinct and indistinct image in the left eye can be eliminated.

I saw this patient a year after my first examination and found the ocular conditions unchanged. She read Jaeger I. (blurred) with either eye. Her fields (roughly taken, owing to unwillingness of patient) for white and red were both contracted, the former much more, proportionately, than the latter. Her health had somewhat improved, but the diplopia had persisted, even under atropine and convex glasses, for both distance and near. The fundi were perfectly normal, and there was no defect of the extrinsic muscles, although the accommodative range was diminished nearly one-fourth.

CASE VI. *Contracture of the ciliary muscle, with monocular polyopia and amblyopia in a young hysterope; temporary cure by suggestion.*—D. N., aged thirteen years, is a nervous, imaginative child and intellectually far advanced beyond her years. Her father is also very "nervous" and has smoked to excess since boyhood. One sister is very delicate, and acts, the mother reports, as if she were going to have St. Vitus' dance. Ever since the child can remember she has had asthenopic symptoms. These were associated with indistinct distant vision and the necessity for holding her book close to her face—a condition unrelieved by any glass which she has ever had. If she reads for more than fifteen minutes the print blurs, her eyes ache, and she has severe supra-orbital pains. Her forehead has wrinkles which show distinctly when she fixes either a near or distant object. She has had double vision for years past. The pupillary reaction is fairly prompt to light, but is slow, imperfect, and irregular when the patient converges. Her central acuity of vision varies from day to day. On the first occasion it was about $\frac{2}{5}$ in each eye, but it has fallen as low as $\frac{1}{5}$. She is always able to read at least words of Jaeger IV., but the amplitude of accommodation is extremely limited. She has no changes in the background whatever, and the media are quite clear. Her refractive error, under atropine, is insignificant, and there is no heterotropia worth speaking about. The double vision, upon a closer examination, resolved itself into monocular polyopia. This curious symptom could not be associated with any other cause than that of hysteria. I have made a number of experiments on the child with particular reference to this phenomenon, and am satisfied of its purely hysterical character.

The patient has contractures of the flexors of the forearm and fingers of the left hand. These are clonic in character, and have persisted for three years. She is very subject to vertigo and to headaches brought on by any attempt to use the eyes. In the course of a pretended examination of her eyes for glasses, vision can often be improved (by using a plane glass, a + or — 0.12 D. lens, or a $\frac{1}{2}$° prism) from $\frac{2}{7}$ to $\frac{2}{3}$ or therabouts. The same is true of the shifting boundaries of her field of vision; it is extremely difficult to map out the areas for red, green, and white, although the latter usually occupies a larger space than the colors. A curious circumstance is that she refers the tones of five different tuning-forks to certain colors (that flash constantly before her closed eyes) while they are vibrating upon her vertex. C produces a brownish color, C^1 black, C^2 yellow, C^3 red, and C^4 yellow or yellow-white, and she is quite consistent in her replies to questions concerning them.

FIG. 4.



Reversal of the color-field in a case of hysterical amblyopia. V = $\frac{2}{7}$.

The patient has, thus far, not permanently improved, although there are days at a time when she seems very much better. Owing to the fact that her eyes are so readily fatigued, it is not easy to determine the limit of her contracted field for white, red, and green. Fig. 4 represents the second attempt of the series, there being very little difference between the two eyes. Red is largest, then comes white, and finally green, which is recognized as blue.

A temporary improvement was obtained in this child by ordering for her "suggestive" glasses. These were weak concave ($\frac{1}{8}$ D.) lenses that could not possibly exert any refractive influence upon sight, but were given her with the positive assurance that they would cure her. For a time the result was magical; she read Jaeger I. with ease and distant vision became nearly normal in either eye. The asthenopic symptoms lessened and the visual fields widened. When the glasses were removed from her eyes she became as blind as ever; when they were replaced the improvement was almost instantaneous. A relapse occurred after a few months and has persisted to the time of writing.

There are numerous other indications afforded by the ocular apparatus of the presence of hysteria.

As a rule, whether the pupils are unusually contracted or dilated, the ordinary reflexes are preserved—that is, they contract when light is thrown upon them, and when the patient is directed to fix a near object—they expand when light is withdrawn, or when he is told to gaze into the far distance.

Hysterical photophobia, not necessarily associated with spasm of the lid muscles, is a common experience in hysteria, and, when present at all, may be so marked as to give rise to a suspicion of organic disease. The absence of all signs of vascular congestion is usually sufficient to exclude the latter. The patient often asserts that the light hurts the eyes even when these organs are covered with a heavy bandage—an exaggeration that should excite the suspicions of any one conversant with the hysterical character.

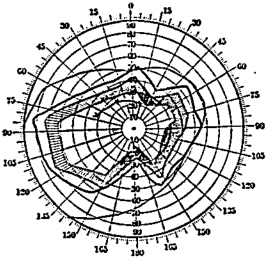
Ring Scotoma. Most observers regard defects in the field of an annular character as presumptive evidence of the presence of hysteria, and, although I should hesitate to rely upon this sign alone in the diagnosis of the neurosis, I have never seen a well-marked instance of its presence where other indications of hysteria were wanting. The following case is so typical that I give it, with the perimeter charts.

CASE VII. *Hysterical asthenopia, with "ring" scotoma and paresis of accommodation, in a young hysterope.*—W. H., aged seventeen years, is a member of a decidedly neurotic family, and has complained of a number of nervous symptoms most of his lifetime. His family physician informs me that he has had and still presents several hysterical stigmata. His school-life has been frequently interrupted by ocular headaches and inability to use his eyes, owing to fatigue and blurring of print. During the past year he has grown and developed abnormally, and looks as if he were twenty years of age. He complains of lassitude and constant fatigue on any exertion. His central vision is good, except that he has 1 D. of hyperopia, and his eye-muscles are normally balanced. He exhibits a marked paresis of accommodation. In either eye, without glasses, the accommodative range is 18″—28″; with a 2 D. + glass it is 9″—25″, with some transient blurring. A careful exploration of his visual fields discovered a curious condition of affairs—the so-called "ring scotoma"—the area of blindness not affecting the extreme periphery of the field nor the central region, but covering an area, roughly speaking, about 10° wide on either side of a parallel of latitude (Figs. 5, 6, 7, and 8.)

These varied in size and situation from time to time as the patient grew better. Complete rest, tonics, massage, and faradization were resorted to, and finally the patient was sent on a three-months' camping excursion to the Rocky Mountains, where he practically recovered.

FIG. 5.

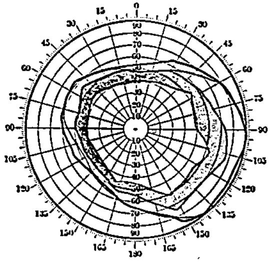
LEFT.



Ring scotoma in a hysteropic boy.

FIG. 6.

RIGHT.



Ring scotoma in a hysteropic boy.

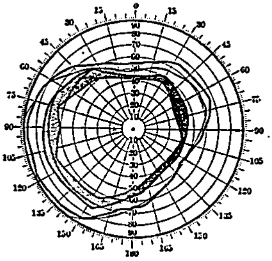
The scotoma has not, so far, entirely disappeared, but all the other hysterical symptoms have, for the time at least, greatly improved. Figs. 5 and 6 show the visual fields taken early in the case, and Figs. 7 and 8, a month afterward.

Anæsthesia of the Palpebral Skin. I have often examined cases of hysterical amblyopia for anæsthesia of the palpebral skin and ocular conjunctiva—noted by Gilles de la Tourette—and have usually found it when hemianæsthesia is also present or where the pharyngeal reflex is wanting or dulled. In other words, the orbicular area shows a want of sensibilty in common with other regions that are most often affected in hysteria.

Pseudo-paralytic Ptosis. This is another purely hysterical stigma. This rather unusual symptom, unlike organic paralysis, is almost always accompanied by other signs of hysteria, especially reflex photophobia, blepharospasm. The eye closes quickly when the hysterical lid is raised; slowly in true paralysis. In unilateral hysterical ptosis, as Charcot observed, the eyebrow is lower on the healthy side; higher in true paralysis.

FIG. 7.

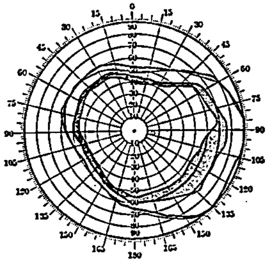
LEFT.



Ring scotoma in hysteropic boy—one month after first perimetric examination.

FIG. 8.

RIGHT.



Field of vision (ring scotoma) in a hysteropic boy—one month after former measurement.

Traumatic Hysteria. Suspicion should be aroused by the appearance of any of the symptoms above detailed if they show themselves after an injury, however trifling, if it be accompanied by mental shock. My personal experience has been that a majority, or large minority, of examples of ocular hysteria belong to the so-called *traumatic neuroses.*

It must not be forgotten that just as hysteria simulates most organic lesions, it may also be present with them. Patrick has, among others, recently emphasized this important fact, and has reported cases illustrative of it. The eye is no exception to this rule, but fortunately organic alterations in the ocular structures, as examined by the ophthalmoscope, perimeter, etc., usually speak for themselves, and present characters entirely unlike those of a purely functional affection.

In conclusion: 1. Most cases of hysteria present well-marked, easily-detected eye-signs and symptoms.

2. A few ocular symptoms, such as reversal of the relation of the color-fields and the field for white, the tonic form of blepharospasm, spasm of accommodation and convergence, and pseudo-paralytic ptosis, may be regarded as pathognomonic of hysteria.

3. Defects of vision (in the absence of refractive errors, accommodative anomalies, and fundus lesions) are, generally speaking, hysterical if accompanied by photophobia and any form of blepharospasm.

4. No examination of a patient for hysteria should be regarded as complete without considering the condition of his ocular apparatus.

5. Where there is no conclusive external evidence of the neurosis present, the perimeter should be carefully used, the range of accommodation should be noted, and the ophthalmoscope employed.

6. It should always be remembered that ocular hysteria is common in children and men.

7. Organic disease (traumatism especially) of the eye may accompany purely functional disturbances of that organ.

For the benefit of those who wish further to pursue this interesting and important matter I append the titles of a few monographs on the subject.[1]

[1] "Traité clinique et thérapeutique de l'hystérie," 1891. Par Gilles de la Tourette.

Charcot's "Lessons on Diseases of the Nervous System."

"De l'amblyopie liée à l'hémianesthésie et spécialement de l'amblyopie hystérique. Thèse de Paris," 1886.

"Ueber Sehstörungen bei functionellen Nervenleiden." Wilbrand und Sänger. Leipzig, 1892.

"Ueber neurotische Asthenopie und die sogenannten Anæsthesie retinæ." Wilbrand. Archiv für Augenheilk., xii., 1893.

Finally, a fair account of ocular hysteria may be read in the fourth volume of Norris and Oliver's "System of Diseases of the Eye," written by Parinaud and translated by myself.